67:15:01:01. Definitions. Terms used in this article mean:

(1) "Boarders," individuals to whom a household furnishes lodging and meals for compensation;

(2) "Congregate living arrangement," the housing shared by two or more individuals who live together;

(3) "Department," the Department of Social Services;

(4) "ECIP," energy crisis intervention program;

(5) "Gross income," for non-self-employed households, earned and unearned income before deductions; for self-employed households, earned and unearned income less business-related expenses except those listed in § 67:15:01:18.01;

(6) "Indian household," a household which is located in a county or portion of a county served by a tribe and has an Indian as the head of the household;

(7) "Institution," a facility that provides living quarters and services for a particular individual or group of individuals, including group homes, nursing homes, higher education facilities, facilities administered by the Department of Human Services under SDCL 1-36A-1.3, facilities administered by the Department of Corrections under SDCL 1-15-1.4, the South Dakota State Veterans' Home administered by the Department of ~~Military and~~ Veterans' Affairs under SDCL ~~33-18-13~~3A-4-1, community residential facilities, community habilitation facilities, residential treatment centers, special education units, residential school programs, and adjustment training centers;

(8) "LIEAP," low income energy assistance program;

(9) "Primary heating source," the main source of heat used by the household;

(10) "Roomers," individuals to whom a household furnishes lodging, but not meals, for compensation;

(11) "Categorically income eligible," if all individuals on the low income energy assistance application receive supplemental nutrition assistance benefits, the household is deemed income eligible for the low income energy assistance program; and

(12) "WIA," the Workforce Investment Act of 1998, Pub. L. 105-220, as amended to July 1, 2009.

Source: 8 SDR 95, effective February 18, 1982; 10 SDR 30, effective October 3, 1983; 11 SDR 96, effective January 27, 1985; 12 SDR 73, effective November 4, 1985; 17 SDR 66, effective November 12, 1990; 23 SDR 101, effective December 22, 1996; 31 SDR 192, effective June 8, 2005; 36 SDR 103, effective December 21, 2009.

General Authority: SDCL 28-1-50.

Law Implemented: SDCL 28-1-46.

Cross-Reference: Definitions, § 67:28:01:01.

67:16:01:01. Definitions. Terms used in this article mean:

(1) "Allowable costs," those expenses incurred in meeting state licensure or federal certification standards for the provision of medical services;

(2) "Applicant," an individual who has filed an application for participation in the medical assistance program;

(3) "Claim form" or "claim," a communication used by providers to request payment for goods or services reimbursable under this article;

(4) “Centers for Medicare & Medicaid Services” or “CMS,” the federal agency that administers the Medicare program and monitors the Medicaid programs offered by each state;

~~(4)~~(5) "Cost sharing," money paid by a recipient to a provider for each covered service or procedure rendered to the recipient or in the recipient's behalf;

~~(5)~~(6) "Department," the Department of Social Services;

~~(6)~~(7) "Disability/incapacity consultation team," a three-member team consisting of a registered nurse and a social worker from the department and a consultant physician;

~~(7)~~(8) "Emergency," a condition that if not immediately diagnosed and treated could cause a person serious physical or mental disability, continuation of severe pain, or death;

~~(8) "Health care financing administration" or "HCFA," the federal agency responsible for the federal administration of the Medicare and Medicaid programs;~~

(9) "Medicaid," the program authorized by Title XIX of the Social Security Act, 42 U.S.C. § 1396d, as amended to ~~January 1, 2000~~ July 1, 2013, which covers the allowable medical expenses of eligible individuals;

(10) "Medical assistance" or "medical assistance program," the Medicaid program authorized by Title XIX of the Social Security Act, 42 U.S.C. § 1396d, as amended to ~~January 1, 2000~~July 1, 2013, and SDCL 28-6, which provides medical assistance to eligible individuals; assistance provided to children who qualify for the non-Medicaid~~nonmedicaid~~ children's health insurance program covered under the provisions of chapter 67:46:14;

(11) "Prior authorization," the written approval and issuance of an authorization by the department to a provider before certain covered services may be provided;

(12) "Reasonable costs," that portion of allowable costs that will be paid for a given medical service;

(13) "Recipient," a person who is determined by the department to be eligible for services under this article;

(14) "SSI," supplemental security income; and

(15) "Usual, customary charge" or "usual and customary," the individual provider's normal charge to the general public for a specific service on the day the service was provided.

Source: SL 1975, ch 16, § 1; 7 SDR 23, effective September 18, 1980; 7 SDR 76, effective February 11, 1981; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 164, effective June 30, 1983; 14 SDR 46, effective September 28, 1987; 15 SDR 2, effective July 17, 1988; 17 SDR 4, effective July 16, 1990; 18 SDR 67, effective October 13, 1991; 26 SDR 168, effective July 1, 2000; 37 SDR 53, effective September 23, 2010.

General Authority: SDCL 28-6-1, 42 U.S.C. § 1396d.

Law Implemented: SDCL 28-6-1, 42 U.S.C. § 1396d.

67:16:01:06.03. Covered services requiring prior authorization. ~~The following services must receive prior authorization by the department:~~

~~(1) Heart transplants;~~

~~(2) Liver transplants;~~

~~(3) Implantable nerve stimulators;~~

~~(4) Panniculectomy;~~

~~(5) Out-of-state neonatal intensive care;~~

~~(6) Botox;~~

~~(7) Synagis;~~

~~(8) Cochlear implants;~~

~~(9) Cosmetic procedures;~~

~~(10) Nonacute, nontraumatic spinal surgery performed in inpatient, outpatient, and specialty hospitals;~~

~~(11) Breast reduction surgery;~~

~~(12) Gastric bypass, gastric stapling, gastroplasty, or any similar surgical procedure performed for weight loss and associated chronic conditions;~~

~~(13) Hyperbaric oxygen therapy;~~

~~(14) Noninvasive bone-growth stimulation;~~

~~(15) Orthodontic treatment;~~

~~(16) Private duty nursing services;~~

~~(17) Extended home health aide services;~~

~~(18) Certain prescription drugs;~~

~~(19) Nonemergency transportation services provided by a commercial carrier;~~

~~(20) Mental health services that exceed the limits of chapter 67:16:41;~~

~~(21) Enternal nutritional therapy for individuals 21 years of age or older; and~~

~~(22) Parenteral nutrition therapy~~

The department requires prior authorization for certain services. The provider shall obtain approval from the department before supplying services subject to prior authorization. Services subject to prior authorization are listed on the department's website located at http://dss.sd.gov/sdmedx/includes/providers/programinfo/pa/index.aspx.

Source: 37 SDR 53, effective September 23, 2010.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:01:08. Services not covered. In addition to items and services specified as not covered in other sections of this article, the following ~~are examples of~~ items and services are not covered under the medical assistance program:

(1) Items or services which have been determined by the state dental or medical consultant or through peer reviews to be not medically necessary, safe, or effective;

(2) Items or services for which the recipient~~beneficiary~~ has no legal obligation to pay or which are charges imposed by immediate relatives or members of the ~~beneficiary's~~ recipient's household;

(3) Over-the-counter drugs, home remedies, food supplements, nutritional items, vitamins, or alcoholic beverages except as covered under chapter 67:16:14 or 67:16:42;

(4) Diagnosis or treatment given in the absence of the patient;

(5) Cosmetic surgery to improve the appearance of an individual when not incidental to prompt repair following an accidental injury or any cosmetic surgery which goes beyond that which is necessary for the improvement of the functioning of a malformed body member;

(6) Items or services provided by practitioners or agencies in the employ of or under contract with the federal, state, or local government, except state institutions for the developmentally disabled which are certified as skilled nursing or intermediate care facilities, the state psychiatric hospital, the public health service, or the national health service;

(7) Organ transplants except as authorized under chapter 67:16:31;

(8) Acupuncture;

(9) Biofeedback;

(10) Chronic pain rehabilitation program services or chronic pain management services except as allowed under chapter 67:16:14;

(11) Alcohol and drug rehabilitation therapy, except for services provided under chapter 67:54:08;

(12) Procedures for implanting an embryo;

(13) Gastric bypass, gastric stapling, gastroplasty, any similar surgical procedure, ~~or any weight loss program or activity~~or the associated conservative weight loss management unless prior authorized;

(14) Self-help devices, exercise equipment, protective outerwear, personal comfort services or environmental control equipment, such as air conditioners, humidifiers, dehumidifiers, heaters, or furnaces;

(15) Medical equipment for a resident in a health care facility, except as authorized under chapter 67:44:03;

(16) Autopsies;

(17) Custodial care, except as authorized under chapter 67:44:03 or chapter 46:10:07;

(18) Nursing facility services for individuals age 21 and over and under age 65 in institutions for mental disease;

(19) Broken appointments;

(20) Reports required solely for insurance or legal purposes unless requested by the department, the Department of Health, or the Department of Human Services;

(21) Concurrent care by more than one provider of the same discipline for the same diagnosis without a medical referral detailing the medical necessity of the concurrent care. For concurrent care without medical referral, the department will pay only the first claim submitted;

(22) A health service that is not documented in the recipient's medical record as required by chapter 67:16:34;

(23) Vocational training, educational activities, teaching, or counseling, except outpatient diabetes self-management education programs covered under the provisions of chapter 67:16:46;

(24) Record keeping, charting, or documentation related to providing a covered service, unless specifically allowed in this article;

(25) Payment of mileage unless specifically covered under this article;

(26) Drugs and biologicals which the federal government has determined to be less than effective as listed in § 67:16:14:05;

(27) Services, procedures, or drugs which are considered experimental by the United States Department of Health and Human Services or another federal agency unless prior authorized;

(28) Incontinence items and pads;

(29) Procedures and services to reverse sterilization;

(30) Computers, computer hookups, or computer printers unless prior authorized; ~~and~~

(31) Gambling addiction services or therapy; and

(32) Penile implants.

Source: SL 1975, ch 16, § 1; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 11, effective August 1, 1982; 9 SDR 164, effective June 30, 1983; 10 SDR 79, effective February 1, 1984; 11 SDR 26, effective August 21, 1984; 11 SDR 86, effective December 30, 1984; 15 SDR 204, effective July 6, 1989; 17 SDR 4, effective July 16, 1990; 17 SDR 184, effective June 6, 1991; 17 SDR 194, effective June 24, 1991; 18 SDR 98, effective December 9, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 165, effective May 3, 1993; 20 SDR 144, effective March 10, 1994; 22 SDR 32, effective September 11, 1995; 28 SDR 166, effective June 12, 2002; 35 SDR 88, effective October 23, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Covered services must be medically necessary, § 67:16:01:06.02.

67:16:01:22. Cost-sharing participants. Cost-sharing participants include those individuals who are at least 21 years of age and who were not residents of a long-term care facility or recipients of home and community-based services on the date the covered service was provided. Cost sharing is required for the services designated in chapters 67:16:02, 67:16:03, 67:16:06, 67:16:07, 67:16:08, 67:16:09, ~~67:16:11,~~ 67:16:13, 67:16:14, 67:16:28, 67:16:29, 67:16:41, 67:16:42, 67:16:44, and 67:16:46.

Source: 9 SDR 164, effective June 30, 1983; 11 SDR 86, effective December 30, 1984; 14 SDR 46, effective September 28, 1987; 16 SDR 114, effective January 15, 1990; 22 SDR 6, effective July 26, 1995; 22 SDR 32, effective September 11, 1995; 23 SDR 109, effective January 5, 1997; 28 SDR 84, effective December 20, 2001; 31 SDR 191, effective June 8, 2005; 35 SDR 88, effective October 23, 2008; 37 SDR 53, effective September 23, 2010.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-References: Cost sharing: Basis and purpose, 42 C.F.R. § 447.50; Cost sharing, §§ 67:16:02:11, 67:16:03:13, 67:16:06:07, 67:16:07:05.01, 67:16:08:08, 67:16:09:07, ~~67:16:11:12,~~ 67:16:13:07, 67:16:14:10, 67:16:28:07, 67:16:29:09, 67:16:41:16, 67:16:42:10, 67:16:44:07, and 67:16:46:07.

CHAPTER 67:16:02

PHYSICIAN AND OTHER HEALTH SERVICES

Section

67:16:02:03.03. Required modifier codes. A modifier provides the means by which the reporting physician indicates on the claim form that a service or procedure that was performed was altered by some specific circumstance but not changed in its definition or code. If applicable, ~~the following~~ modifier codes must be included on the provider's claim for services~~:~~. A list of authorized modifier codes is available on the department's website located at http://dss.sd.gov/sdmedx/modifiers.asp.

~~MODIFIER DESCRIPTION~~

~~-21 Prolonged evaluation and management services. If the face-to-face or floor/unit service provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service, it must be identified by adding modifier "-21" to the usual procedure code. A report may be appropriate.~~

~~-22 Unusual services. If the service provided is greater than that usually required for the listed procedure, it must be identified by adding modifier "-22" to the usual procedure code. A report may be appropriate.~~

~~-23 Unusual anesthesia. If a procedure which normally requires either no anesthesia or local anesthesia must be done under general anesthesia because of unusual circumstances, it must be identified by adding modifier "-23" to the usual procedure code.~~

~~-26 Professional component. Certain procedures are a combination of a physician component and a technical component. If the physician component is reported separately, the service must be identified by adding the modifier "-26" to the usual procedure code.~~

~~-47 Anesthesia by surgeon. The operating surgeon may not use modifier "-47" in addition to the basic procedure code. Anesthesia provided by the surgeon is part of the basic procedure being provided.~~

~~-50 Bilateral procedure. Unless otherwise identified in this listing, bilateral procedures requiring a separate incision that are performed at the same operative session must be identified by the applicable five-digit code describing the first procedure. The second (bilateral) procedure is identified by adding modifier "-50" to the procedure code.~~

~~-51 Multiple procedures. If multiple procedures are performed on the same day or at the same session, the major procedure or service must be reported as listed. The secondary, additional, or lesser procedure or service must be identified by adding the modifier "-51" to the secondary procedure or service code. This modifier must be used to report multiple medical procedures performed at the same session, as well as a combination of medical and surgical procedures or several surgical procedures performed at the same operative session. Bilateral~~

procedures and surgical procedures which cannot stand alone but which are performed as a part of a primary surgical procedure, such as procedure code 15261, are not considered multiple medical procedures and may not be reported with a "-51" modifier. -52 Reduced services. Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided must be identified by its usual procedure code and the addition of the modifier "-52" signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

-53 Discontinued procedure. If a procedure is started but discontinued because of extenuating circumstances or those that threaten the well-being of the patient, the service provided must be identified by its usual procedure code and the addition of the modifier "-53".

-54 Surgical care only. If one physician performs a surgical procedure and one or more other physicians provide preoperative or postoperative management, surgical services must be identified by adding the modifier "-54" to the usual procedure code.

-55 Postoperative management only. If one physician performs the postoperative management and another physician performs the surgical procedure, the postoperative component must be identified by adding the modifier "-55" to the usual procedure code.

-56 Preoperative management only. If one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component must be identified by adding the modifier "-56" to the usual procedure code.

-59 Distinct procedural service. Valid if attached to a procedure code that is distinct or independent from the other services performed on the same date of service. This includes a different session or encounter, different incision/excision, different organ, separate lesion.

-62 Two surgeons.

-73 Discontinued out-patient procedure prior to anesthesia administration. If extenuating circumstances or those that threaten the well-being of the patient cause the physician to cancel a surgical or diagnostic procedure after the patient's surgical preparation, but before the administration of anesthesia, the service provided must be identified with its usual procedure code and the addition of a modifier "-73".

-74 Discontinued out-patient procedure after anesthesia administration. If extenuating circumstances or those that threaten the well-being of the patient cause the physician to terminate a surgical or diagnostic procedure after the administration of anesthesia or after the procedure was started, the service must be identified with its usual procedure code and the addition of modifier "-74".

-76 Repeat procedure by same physician. If the physician repeats a procedure or service subsequent to the original procedure or service, the repeated procedure or service must be reported with its usual procedure code and the addition of a modifier "-76".

-77 Repeat procedure by another physician. If another physician repeats a procedure or service subsequent to the original procedure or service, the repeated procedure or service must be reported with its usual procedure code and the addition of a modifier "-77".

-78 Return to the operating room for a related procedure during the postoperative period. If another procedure was performed during the postoperative period of the initial procedure and the subsequent procedure is related to the first and requires the use of the operating room, the procedure must be reported with its usual procedure code and the addition of a modifier "-78".

-79 Unrelated procedure or service by the same physician during the postoperative period. If another procedure or service is performed during the postoperative period and the subsequent procedure is unrelated to the original procedure, the procedure must be reported with its usual procedure code and the addition of a modifier "-79".

-80 Assistant surgeon. Surgical assistant services must be identified by adding the modifier "-80" to the usual procedure code.

-81 Minimum assistant surgeon. Minimum surgical assistant services must be identified by adding the modifier "-81" to the usual procedure code.

-82 Assistant surgeon if qualified resident surgeon not available. The unavailability of a qualified resident surgeon is a prerequisite for use of modifier "-82" appended to the usual procedure code.

-AA Anesthesia services performed personally by anesthesiologist.

-AD Anesthesia services; Medical supervision by a physician; more than four concurrent anesthesia procedures.

-AS Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery.

-QK Anesthesia services; Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.

-QX Anesthesia services; CRNA service, with medical direction by a physician.

-QY Anesthesia services; Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist.

-QZ Anesthesia services; CRNA service, without medical direction by a physician.

~~-SL State supplied vaccine.~~

~~-TC Technical component.~~

Source: 17 SDR 200, effective July 1, 1991; 23 SDR 38, effective September 26, 1996; transferred from Appendix D, chapter 67:16:02, 34 SDR 68, effective September 12, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:02:05.12 Cochlear implant – Prior authorization required. ~~A cochlear implant is covered on prior authorization from the department. Authorization is based on written documentation submitted to the department by the physician that confirms the following:~~

~~(1) The implant will provide an awareness and identification of sound and will facilitate communication;~~

~~(2) There is a diagnosis of sensorineural hearing loss that is not clinically improved by the use of a hearing aid;~~

~~(3) The individual has a cochlea that will accept an implant;~~

~~(4) There are no lesions of the individual's auditory nerve or acoustic areas of the central nervous system; and~~

~~(5) The individual demonstrates the cognitive ability to use auditory clues and there is a willingness to undergo an extended program of rehabilitation.~~

~~Services, supplies, and implant systems are not covered if the request is to replace or upgrade a device that is functioning appropriately~~Repealed.

Source: 28 SDR 178, effective July 3, 2002.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

~~**Cross-Reference:** Covered services must be medically necessary, § 67:16:01:06.02.~~

67:16:02:17. Claim requirements. A claim for services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3) Third-party liability information required under chapter 67:16:26;

(4) Date of service;

(5) Place of service;

(6) The provider's usual and customary charge. The provider may not subtract other third-party or cost-sharing payments from this charge;

(7) Units of service furnished if more than one;

(8) The applicable procedure codes from either the CMS Common Procedure Coding System (HCPCS) or the Physicians' Current Procedural Terminology;

(9) Diagnosis codes as contained in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) adopted in § 67:16:01:26;

(10) The provider's name and ~~medical assistance identification~~ National Provider Identification (NPI) number;

(11) If the provider is a group provider, the ~~medical assistance identification~~ National Provider Identification number of the physician who provided the care or service;

(12) Type of service; and

(13) The modifier code listed in § 67:16:02:03.03, as applicable.

A separate claim must be submitted for each recipient.

Source: 17 SDR 4, effective July 16, 1990; 17 SDR 22, effective August 14, 1990; 17 SDR 200, effective July 1, 1991; 18 SDR 78, effective November 4, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 128, effective March 11, 1993; 19 SDR 165, effective May 3, 1993; 20

SDR 149, effective March 21, 1994; 21 SDR 183, effective April 30, 1995; 34 SDR 68, effective September 12, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-References:

Claims, ch 67:16:35.

Use of cpt, § 67:16:01:25.

Use of HCPCS, § 67:16:01:27.

Note: The CMS 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department. These forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

67:16:03:07. Payment of hospital services. Payments to hospitals for services provided to eligible individuals shall be made for medically necessary services provided on an inpatient or outpatient basis and for deductibles and coinsurance under the Medicare program.

A readmission ~~to the same hospital for the same diagnosis on the same day as the day of discharge~~ within 72 hours from the time of discharge to same hospital for a related diagnosis is considered a continuation of the prior admission for payment purposes.

Readmission or return to a hospital following a leave of absence, regardless of length, is not considered a separate admission.

Source: SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 164, effective June 30, 1983; 16 SDR 239, effective July 9, 1990; 17 SDR 180, effective May 27, 1991.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Services not covered, § 67:16:01:08.

67:16:05:05.01. Service restrictions. Home health services must meet the following criteria:

(1) They must be provided by a home health agency employee who is qualified to perform the required service;

(2) They must be prescribed by the attending physician and contained in the home health agency's written plan of care;

(3) They must be provided at the individual's place of residence, which does not include a hospital, penal institution, detention center, school, nursing facility, intermediate care facility for the mentally retarded, or an institution which treats individuals for mental diseases; and

(4) ~~They must be provided to an individual who has a medical condition caused by an illness or injury and for whom leaving the home would require a considerable effort and the assistance of another individual or the aid of supportive devices. This provision may be waived for postpartum services or when leaving the home is medically contraindicated by a physician. An individual's age alone does not qualify the person for home health services; and~~

~~(5)~~ They must be provided intermittently but not more than once a day and no more frequently than five days a week, except as specified by subdivision 67:16:05:05(4).

If Medicare denies payment for a service because there is no medical necessity, the individual is ineligible for services under this chapter.

Source: 16 SDR 111, effective January 7, 1990; 16 SDR 233, effective July 1, 1990; 18 SDR 203, effective July 1, 1992; 33 SDR 137, effective March 7, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:08:05. Services not covered. The department does not cover the following items or services and, if provided, reimbursement must be obtained from the recipient:

(1) Extended wear or daily disposable contact lenses;

(2) Regular eyeglasses or contact lenses when used to supplement another pair of corrective vision lenses;

(3) Athletic glasses;

(4) Tinting, additional charges for photochromic lenses, lens decoration, or special lens coating;

(5) Frames if a lens change is not medically necessary; ~~and~~

(6) LASIK surgery; and

(7) Consultation services.

The provisions of this rule are not applicable to the items or services provided for children under the age of 21 if documented as medically necessary.

Source: 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 86, effective December 30, 1984; 16 SDR 64, effective October 8, 1989; 16 SDR 235, effective July 5, 1990; 17 SDR 200, effective July 1, 1991; 20 SDR 159, effective April 6, 1994; 22 SDR 94, effective January 10, 1996; portions of this rule were transferred to § 67:16:08:04, 35 SDR 49, effective September 10, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:25:04.02. Wheelchair transportation -- Required training for driver and attendant. A wheelchair transportation provider ~~muse~~ must ensure that each driver and attendant is able to assist a passenger into and out of a vehicle and each receives the following training:

(1) Before providing services, instruction in the operation of the vehicle ramp, wheelchair lift, and wheelchair securement devices;

(2) Before providing services, instruction in the procedures ~~to follow~~ in case of a medical emergency or an accident, including first aid;

(3) Before providing services, instruction in the use of the fire extinguisher located in the vehicle ~~used for wheelchair transportation;~~.

~~(4) Before providing services, instruction in the area of passenger sensitivity;~~

~~(5) Within 45 days after the driver or attendant begins providing services, four hours of training in first aid, including treatment of shock; control of bleeding; airway management; prevention and treatment of frostbite and exposure to cold; prevention and treatment of heat exhaustion and heat stroke; prevention of bloodborne pathogens; and recognition of sudden illnesses, such as stroke, heart attack, convulsions, fainting, and seizures. This requirement does not apply to a person who possesses a current basic or advanced first aid certification by the American Red Cross or a current certification as an emergency medical technician;~~

~~(6) Within 45 days after the driver or attendant begins providing services, four hours of classroom instruction in defensive driving; and~~

~~(7) Within 60 days after the driver or attendant begins providing services, eight hours of training in moving wheelchairs up and down steps, curbs, ramps, and lifts; handling a wheelchair on uneven, wet, or icy surfaces; folding and unfolding a manual wheelchair; the proper use and operation of the lift, ramp, and wheelchair securement devices; and the functional limitations of the aging process and major disabling conditions and how those conditions affect mobility and communication, including speech; balance; loss of limbs, muscle control, skin sensation, and temperature control; breathing disorders; vision and hearing impairments; and paralysis~~handling

~~a wheelchair in all surface and weather conditions and operation of wheelchair ramp, lift, and securement devices.~~

~~At least once every three years, the provider must ensure that each driver and attendant has completed a refresher course covering those items contained in subdivisions (5) and (6) of this section.~~

Source: 25 SDR 83, effective December 15, 1998.

General Authority: SDCL 28-6-1(2)(4).

Law Implemented: SDCL 28-6-1(2)(4).

67:16:25:06.04. Transportation services provided by recipient, escort, or volunteer driver. Non-emergency transportation services provided by the recipient, an escort, or a volunteer driver are covered if the following requirements are met:

(1) The expenses are covered under § 67:16:25:06.07;

(2) The transportation is outside the recipient's city of residence;

(3) Transportation is from an eligible recipient's city of residence to a medical provider located in another city, between medical providers located in different cities, or from a medical provider located in one city to the recipient's city of residence;

(4) Transportation is to or from medically necessary examinations or treatment when the services are covered under article 67:16 or chapter 67:46:10 and are provided by a provider who is enrolled or eligible for enrollment in the medical assistance program; or the transportation is between a medical provider and the recipient's city of residence and is for the purpose of allowing a parent or guardian to travel to visit a child who is in a hospital or medical facility and receiving medically necessary services covered under article 67:16 and the travel is necessary to meet the requirements of the child's service care plan; and

(5) Transportation is to the closest facility or medical provider capable of providing the necessary services, unless the recipient has a written referral or a written authorization from the recipient's medical provider; or the transportation is for a visit referred to in subdivision (4) of this section.

The department may waive any of the conditions contained in the above subsections if paying for the transportation costs results in a cost savings for the department.

Source: 35 SDR 253, effective May 12, 2009.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:26:05. Provider must collect from third-party source before submitting claim to department -- Medical assistance program payer of last resort -- Payment provision. Because the medical assistance program is the payer of last resort, a provider must pursue the availability of third-party payment sources whether or not the sources are identified by the department.

The provider must be able to document the provider's pursuit of the availability of a third-party payment source, except for claims listed in § 67:16:26:07.02. The documentation must be maintained in the recipient's records. Documentation may include a signed statement by the recipient informing the provider of all third-party payment sources.

Once the provider has identified a third-party payment source, the provider must submit a completed claim for payment of services to the third-party source before requesting payment from the department. Except for an electronic claim, if a claim is subsequently submitted to the department for payment, evidence of third-party payment or rejection must accompany the claim. For an electronic claim, the provider must maintain and submit to the department on request evidence of the third-party payment or rejection. The provider is eligible to receive the recipient's third party liability responsibility amount or the amount allowed under the department's payment schedule less the third-party liability ~~payment~~ amount, whichever is less.

The department may not pay for any service that has been denied by the third-party liability source as not meeting the requirements for submitting a claim.

Source: 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 226, effective June 24, 1990; 17 SDR 194, effective June 24, 1991; 26 SDR 168, effective July 1, 2000; 31 SDR 214, effective July 6, 2005.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-References:

Department determination of possible existence of third-party source -- Claim denial, § 67:16:26:07;

Certain claims eligible for payment before third-party benefits recovered -- Department to pursue reimbursement, § 67:16:26:07.02;

Records, ch 67:16:34.

67:16:25:06.07 Covered services -- Recipient, escort, or volunteer driver. The following transportation services are covered if the service meets the requirements of § 67:16:25:06.04 and are provided by the recipient, an escort, or a volunteer driver:

(1) Loaded mileage if the transportation is outside the recipient's city of residence and provided when all other means of available transportation are of the same or greater cost and the availability of transportation at no cost to the department does not exist;

(2) Mileage driven by a volunteer driver who lives in another city and drives to the recipient's city of residence to transport the recipient when there is no other means of transporting the recipient;

(3) Mileage driven by a parent or guardian to travel to visit a child who is in a hospital or medical facility and receiving medically necessary services covered under article 67:16 or chapter 67:46:10 and the travel is necessary to meet the requirements of the child's service care plan;

(4) Mileage if the transportation is outside the recipient's city of residence and the escort or volunteer driver is returning to the point of origin after delivering the recipient to a medical provider;

(5) Mileage when the transportation is outside the recipient's city of residence to transport a recipient who is being discharged from a hospital or medical facility;

(6) Lodging for travel to or from a medical provider if the provider is at least 100 miles from the recipient's city of residence and travel is to obtain specialty care or treatment that results in an overnight stay. Lodging is limited to 14 days for each medical stay unless the department prior authorizes additional days. A recipient may not receive reimbursement for lodging for days the recipient is an inpatient in a hospital or medical facility; and

(7) Meals for travel to or from a medical provider if the provider is outside the recipient's city of residence and travel is to obtain specialty care or treatment that results in an overnight stay. Meals are limited to 14 days for each medical stay unless the department prior authorizes

additional days. A recipient may not receive reimbursement for meals for days the recipient is an inpatient in a hospital or medical facility.

The department may waive any of the conditions of this section if paying for the transportation costs results in a cost savings for the department.

Source: 35 SDR 253, effective May 12, 2009.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:31:02. Organ transplants covered. Kidney transplants and cornea transplants are covered for adults. Other non-experimental organ transplant procedures are covered for adults if prior authorization is obtained from the department.

~~(1) Kidney transplants;~~

~~(2) Bone marrow transplants which have had prior authorization from the department;~~

~~(3) Cornea transplants;~~

~~(4) Heart transplants for individuals who have obtained prior written authorization from the department; and~~

~~(5) Liver transplants for individuals who have obtained prior written authorization from the department.~~

~~An organ transplant for a child under the age of 21 is subject to prior approval by the department, must be medically necessary, and may not be experimental.~~

Source: 15 SDR 204, effective July 6, 1989; 16 SDR 234, effective July 2, 1990; 17 SDR 200, effective July 1, 1991; 19 SDR 160, effective April 26, 1993; 35 SDR 88, effective October 23, 2008; 37 SDR 53, effective September 23, 2010.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:35:06. Medical assistance cross-over claim requirements. A cross-over claim may be submitted to the department if the provider's claim to Medicare did not trigger an automatic payment of the deductible or co-insurance. Proof of payment by Medicare must be attached. A cross-over claim must contain the following information:

(1) The provider's name and ~~medical assistance identification number~~National Provider Identification (NPI) number and taxonomy code;

(2) The recipient's full name and medical assistance identification number from the recipient's medical assistance identification card;

(3) Third-party liability information required under chapter 67:16:26;

~~(3)~~(4) The date of service;

~~(4)~~(5) The place of service;

(6) The provider's usual and customary charge billed to Medicare;

(7) Units of service furnished, if more than one;

(8) The applicable procedure code from the **CMS Common Procedure Coding System (HCPCS)** or the **Physicians' Current Procedural Terminology**;

(9) The amount paid by Medicare plus the Medicare discount or write off amount~~The amount of Medicare deductible or co-insurance being billed to the medical assistance program~~;

~~(5)~~(10) Proof of the deductible or co-insurance, which must be attached;

~~(6)~~(11) The amount paid by third-party payers other than Medicare, if any;

~~(7)~~(12) The amount originally billed to Medicare; and

~~(8)~~(13) The type of Medicare coverage.

Source: 17 SDR 4, effective July 16, 1990; 17 SDR 184, effective June 6, 1991.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:35:11. Claim forms and copies. ~~Except for nursing facility claims, claim forms accepted by the department consist of an original and a copy. The original must be submitted to the department and the copy must be retained by the provider~~Repealed.

Source: 17 SDR 4, effective July 16, 1990.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

~~**Cross-Reference:** Claim requirements, § 67:45:02:12.~~

67:16:37:01. Definitions. Terms used in this chapter mean:

(1) "Care plan" or "plan of care," a written plan for a particular individual which outlines medically necessary health services and the duration of those services;

(2) "School district," an education unit defined by SDCL 13 5 1; an agency which operates a special education program for children with disabilities, birth through 21 years of age, which program meets the requirements of article 24:05; a cooperative special education unit created by two or more school districts under SDCL 13 5 32.1;

(3) "Speech therapist," an individual who meets the requirements of ~~§ 24:02:03:22~~ § 24:15:02:01 and works under the direction and supervision of a speech pathologist who meets the requirements for a speech pathologist contained in subdivision 67:16:37:05(4); and

(4) "Unit," a 15 minute measurement of time or fraction thereof.

Source: 18 SDR 78, effective November 4, 1991; 18 SDR 224, effective July 13, 1992; 19 SDR 172, effective May 19, 1993; 24 SDR 86, effective January 1, 1998.

General Authority: SDCL 28 6 1(1).

Law Implemented: SDCL 28 6 1(1).

67:16:37:06. Covered psychological services. Psychological services are limited to the following:

(1) ~~Psychological testing, with written report~~Integrated screening, assessment, and evaluation;

(2) ~~Diagnostic assessment, therapeutic contacts with the recipient, family, and significant others to the extent necessary to complete an accurate psychological evaluation and diagnosis, limited to two hours annually per recipient unless there is at least a break of 12 months in providing psychological services~~Individual therapy;

(3) ~~Individual medical psychotherapy, one-to-one and face-to-face contact between the recipient and the provider, including psychoanalysis or insight-oriented, behavior modifying, or supportive psychotherapy, not to exceed 60 hours in any 12-month period~~Group therapy;

(4) ~~Family medical psychotherapy (conjoint psychotherapy), face-to-face contact between the recipient and the provider and one or more family members, including psychoanalysis or insight-oriented, behavior-modifying, or supportive psychotherapy, not to exceed 60 hours in any 12-month period~~Parent or guardian group therapy; and

(5) ~~Multiple-family group medical psychotherapy; face-to-face contact between the recipient, the provider, and more than one family, including psychoanalysis or insight-oriented, behavior modifying, or supportive psychotherapy, not to exceed 60 hours in any 12-month period~~Family education, support, and therapy~~;~~

~~(6) Group medical psychotherapy (other than of a multiple-family group); face-to-face contact between the recipient, the provider, and one or more group members including psychoanalysis or insight-oriented, behavior-modifying, or supportive psychotherapy not to exceed 60 hours in any 12-month period~~.

Source: 18 SDR 78, effective November 4, 1991; 18 SDR 224, effective July 13, 1992.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-References: Rate of payment, § 67:16:37:12; Billing requirements, § 67:16:37:14.

67:16:37:14. Billing requirements. A school district submitting a claim for covered services under this chapter must submit the claim at its usual and customary charge.

The school district must submit the claim when the service is listed in the child's individual education plan and is covered under this chapter. Services provided to an individual who has been admitted to a hospital as an inpatient, or who is residing in a residential treatment center, a nursing facility, or an intermediate care facility for the mentally retarded are exempt from the provisions of this rule. Claims for these services must be submitted according to the applicable chapters of article 67:16.

A provider, other than those listed above, may not submit claims for services which the provider knows or should have known are services listed in the child's individual education plan.

~~Claims submitted for psychological services listed in § 67:16:37:06 must use procedure code 90899 and may not exceed 60 hours in any 12 month period;~~

~~Claims submitted for physical therapy services must use procedure code 97799.~~

~~Claims submitted for occupational therapy services must use procedure code W4510.~~

~~Claims submitted for speech therapy services must use procedure code 92507.~~

~~Claims submitted for audiology services must use procedure code 92599.~~

~~Claims submitted for nursing services listed in § 67:16:37:11 must use procedure code W4710.~~

Source: 18 SDR 78, effective November 4, 1991; 18 SDR 224, effective July 13, 1992.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:37:15. Claim requirements. A claim for services provided under this chapter must be submitted on a form which contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3) The third-party liability information required under chapter 67:16:26;

(4) The date of service;

(5) The place of service;

(6) The provider's usual and customary charge. The provider may not subtract other third-party or cost-sharing payments from this charge;

(7) The applicable procedure codes listed in § 67:16:37:14 for the service provided;

(8) The units of service furnished, if more than one; and

(9) The provider's name and ~~medical assistance identification~~National Provider Identification number.

A separate claim form must be used for each recipient.

Source: 18 SDR 78, effective November 4, 1991; 18 SDR 224, effective July 13, 1992.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Note: The ~~HCFA~~ CMS 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department. These forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

67:16:41:03. Mental health provider. A mental health provider must be a psychologist, a licensed professional counselor - mental health, a clinical nurse specialist, or a certified social worker-PIP who has a signed provider agreement with the department to provide mental health services.

A mental health provider must have a National Provider Identification (NPI) ~~medical assistance provider identification~~ number and may not provide services under another provider's medical assistance provider ~~identification~~ NPI number.

An individual who does not meet the certification or licensure requirements of the applicable profession may not enroll as a mental health provider or participate in the delivery of mental health services.

Source: 22 SDR 6, effective July 26, 1995; 26 SDR 168, effective July 1, 2000; 37 SDR 53, effective September 23, 2010.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Provider requirements, ch 67:16:33.

67:16:41:13. Claim requirements. A claim for services provided under this chapter must be submitted on a form which contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical identification card;

(3) Third-party liability information required under chapter 67:16:26;

(4) Date of service;

(5) Place of service;

(6) The provider's usual and customary charge. The provider may not subtract other third-party or cost-sharing from this charge;

(7) Units of service furnished, if more than one;

(8) The applicable procedure codes contained in § 67:16:41:09;

(9) The applicable diagnosis codes contained in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) adopted in § 67:16:01:26;

(10) The provider's name and ~~medical assistance identification~~National Provider Identification number; and

(11) Type of service provided.

Source: 22 SDR 6, effective July 26, 1995.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Claims, ch 67:16:35.

Note: The ~~HCFA~~ CMS 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department. These forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

67:16:42:03. Enteral nutritional therapy for individual 21 years of age and older. Enteral nutritional therapy for an individual who is 21 years of age or older is covered if all of the following conditions are met:

(1) The individual is not institutionalized and services are delivered in the individual's residence. For purposes of this rule, an individual's residence does not include an acute care hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for individuals with a mental disease;

(2) The individual has a permanently inoperative internal body organ or an inoperative body function;

(3) There is a physician's order or prescription for the therapy and sufficient medical documentation describing the medical necessity for the therapy; and

(4) The provider has received prior approval from the department~~; and~~

~~(5) Enteral nutritional therapy is the only means the individual has to receive nutrition~~.

Enteral nutritional therapy is covered if the individual has a functioning gastrointestinal tract but cannot maintain weight and strength commensurate with the individual's general condition because of pathology to or the nonfunction of the structures that normally permit food to reach the digestive tract.

Source: 22 SDR 32, effective September 11, 1995.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:42:04. Enteral nutritional therapy for individual 21 years of age and older -- Prior authorization required. The department ~~must~~ shall authorize the use of enteral nutritional therapy for an individual 21 years of age or older before the service is payable under this chapter. Before authorization is given, the physician ~~must~~ shall provide sufficient medical documentation, including a written order or prescription, to the department describing the diagnosis and the medical necessity for the therapy.

~~An authorization may not exceed three months and a new prescription must be submitted annually~~Prior authorization and a new prescription are required annually. If an initial authorization or an annual reauthorization is being requested or if there is a change in the physician's orders, documentation must include the following:

(1) A copy of the prescription for the needed therapy;

(2) A copy of the physician's statement giving the reasons the person is unable to receive adequate nutrition by normal means;

(3) The applicable procedure codes for the items and services provided;

(4) The provider's usual and customary charge for the items or services, including formula, durable medical equipment, and supplies; and

(5) Documentation regarding other requested routine medical services, such as home health services.

If there is no change in the physician's orders and ~~a three-month~~ an annual reauthorization is being requested, documentation need only include the physician's certification that the individual continues to need the nutritional therapy.

The department may verbally authorize services when the required information is transmitted to the department. The department shall verify a verbal authorization in writing following receipt of the required written documentation.

Source: 22 SDR 32, effective September 11, 1995; 35 SDR 49, effective September 10, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:42:05. Parenteral nutritional therapy. Parenteral nutritional therapy is covered if ~~all of the following conditions are met~~:

(1) The individual is not institutionalized and services are delivered in the individual's residence. For purposes of this rule, an individual's residence does not include an acute care hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for individuals with a mental disease;

(2) The individual has a permanently inoperative internal body organ or an inoperative body function such as severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the individual's general condition;

(3) There is a physician's order or prescription for the therapy and medical documentation describing the diagnosis and the medical necessity for the therapy;

(4) The provider has received prior approval from the department; and

(5) Parenteral nutritional therapy is the only means the individual has to receive nutrition.

Source: 22 SDR 32, effective September 11, 1995.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:44:06. Rate of payment. Payment to a provider for services provided to an eligible individual under this chapter is based on the provider's cost report required under § 67:16:44:05.

Payment is made at an all-inclusive rate for each visit for covered services. The department follows the standards established by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, Title II, § 702 (114 Stat. 2763A-572), December 21, 2000, to determine a facility's rate of payment.

In the absence of specific regulations relating to allowable costs, the department bases allowable cost decisions on the Medicare Provider Reimbursement Manual (~~HCFA~~CMS Pub. 15-1), as specified in § 67:16:04:62.

Source: 23 SDR 109, effective January 5, 1997; 33 SDR 44, effective September 20, 2006.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Definition of rural primary care hospital, SDCL 34-12-1.1.

67:16:46:06. Claim requirements. A claim submitted under this chapter must be submitted at the provider's usual and customary charge and must contain the applicable procedure codes contained in § 67:16:46:05. The claim for services must be submitted on a form that contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance number from the recipient's medical assistance identification card;

(3) Third-party liability information required under chapter 67:16:26;

(4) Date of service;

(5) Place of service;

(6) The provider's usual and customary charge. The provider may not subtract other third-party or cost-sharing payments from this charge;

(7) The procedure codes for services covered under § 67:16:46:05;

(8) The units of service furnished, if more than one; and

(9) The provider's name and ~~medical assistance identification~~ National Provider Identification number.

A separate claim form must be used for each recipient.

Source: 28 SDR 84, effective December 20, 2001.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Claims, ch 67:16:35.

Note: The ~~HCFA~~CMS 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department. These forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

67:16:47:05. Prior approval required for admission. Before an individual may be admitted to a facility for treatment, the certification team must approve the individual's admission to the facility. Approval is based on a review of the following documentation:

(1) The individual's social history that includes past and current behaviors that have prompted the request for admission to a residential facility;

(2) A psychological or psychiatric evaluation and diagnosis that was completed within the past 12 months, if available;

(3) A summary of the individual's behaviors during school from the individual's school district, if available;

(4) Copies of the discharge summaries from previous acute inpatient psychiatric hospitalizations, if applicable;

(5) A summary of outpatient care services that have been provided, including outcomes and recommendations; and

(6) An alcohol and drug screening assessment, if available.

The placing agency shall gather and supply to the department the required documentation.

For emergency admissions, the certification team shall complete its review on the first working day following the date of admission into the residential treatment center.

Source: 32 SDR 33, effective August 31, 2005; 34 SDR 180, effective December 26, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 26-6-14, 28-6-1.

67:45:02:12. Claim requirements. ~~Each month the department will send a two-part claim form to the provider. The first part contains a listing of the individuals who were present at the provider's facility during the last billing period. The provider must complete the second part by correcting any errors listed in the first part and adding the new resident information required under § 67:45:02:13.~~

~~For each individual listed, the provider must indicate on the claim the individual's status using one of the following codes:~~

~~(1) 0 - reserved bed days;~~

~~(2) 1 - transferred to a hospital;~~

~~(3) 2 - transferred to another nursing facility;~~

~~(4) 4 - reserved bed days - patient died;~~

~~(5) 5 - discharged to home for self-care;~~

~~(6) 6 - discharged to home under home health agency care;~~

~~(7) 7 - left against advice;~~

~~(8) 8 - died;~~

~~(9) 9 - patient on therapeutic leave; or~~

~~(10) Blank - still a patient.~~

~~The provider or the provider's authorized agent must sign and date the second part and return the entire form to the department.~~

A claim for services provided under this chapter must be submitted on the CMS 1450 (UB-04) form or in an electronic format that contains the following:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3) Third-party liability information as required under chapter 67:16:26;

(4) Beginning and end dates of service. A provider may only bill for one month at a time;

(5) The number of covered days;

(6) The total charges;

(7) The type of bill;

(8) The provider's name, address, telephone number, and National Provider Identification (NPI) number;

(9) Diagnosis codes as contained in the **International Classification of Diseases, 9th Revisions, Clinical Modification** (ICD-9-CM);

(10) The patient status code indicating the patient's status on the final date of service of the billing period; and

(11) The revenue code identifying the specific accommodation, ancillary service, or billing calculation.

A separate claim form must be submitted for each recipient.

Source: 17 SDR 4, effective July 16, 1990; transferred from § 67:16:04:31, 18 SDR 67, effective October 13, 1991.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Claims, ch 67:16:35.

67:46:01:01. Definitions. Terms used in this article mean:

(1) "AFDC," the aid to families with dependent children program as it existed on July 16, 1996 under the provisions of article 67:12;

(2) "Applicant," an individual who has filed an application for participation in the medical assistance program;

(3) "Department," the Department of Social Services;

~~(4) "Health care financing administration" or "HCFA," the federal agency responsible for the federal administration of the medicare and medicaid programs;~~

~~(5)~~(4) “Medicaid,” the program authorized by Title XIX of the Social Security Act, 42 U.S.C. § 1396d, as amended to January 1, 2000, which covers the allowable medical expenses of eligible individuals;

~~(6)~~(5) "Medical assistance," "medical services," or "medical assistance program," the medicaid program authorized by Title XIX of the Social Security Act, 42 U.S.C. § 1396d, as amended to January 1, 2000, and SDCL 28-6, which provides medical assistance to eligible individuals but does not necessarily include long-term care; assistance provided to children who qualify for the nonmedicaid children’s health insurance program covered under the provisions of chapter 67:46:14;

~~(7)~~(6) "Prior authorization," the written approval and issuance of an authorization by the department to a provider before certain covered services may be provided;

~~(8)~~(7) "Qualified alien," a legal alien who arrived in the United States after August 21, 1996, who meets either the requirements of Pub. L. 104-193, § 431(b) (110 Stat. 2274) (August 22, 1996) or the requirements of Pub. L. 104-193, § 403(b)(2) (110 Stat. 2265) (August 22, 1996);

~~(9)~~(8) "Recipient," a person who is determined by the department to be eligible for services under this article; and

~~(10)~~(9) "SSI," supplemental security income.

Source: SL 1975, ch 16, § 1; 7 SDR 23, effective September 18, 1980; 7 SDR 76, effective February 11, 1981; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 164, effective June 30, 1983; 14 SDR 46, effective September 28, 1987; 15 SDR 2, effective July 17, 1988; 17 SDR 4, effective July 16, 1990; 18 SDR 67, effective October 13, 1991; portions of this rule was copied from § 67:16:01:01, 19 SDR 26, effective August 23, 1992; 19 SDR 141, effective March 25, 1993; 20 SDR 92, effective December 21, 1993; 23 SDR 152, effective March 14, 1997; 24 SDR 24, effective August 31, 1997; 26 SDR 168, effective July 1, 2000.

General Authority: SDCL 28-6-1, 42 USC 1396d.

Law Implemented: SDCL 28-6-1, 42 USC 1396d.

67:46:10:09. Scope of services and benefits. Services and benefits which may be paid under the program include the following:

(1) Institutional dialysis;

(2) Home dialysis, including supplies, equipment, and special water softeners;

(3) Renal transplants;

(4) Hospitalization;

(5) Prescription drugs necessary for dialysis or transplants not covered by other sources; and

(6) Travel expenses for the ~~client only may be allowed as follows:~~

~~(a) Mileage at 24 cents a mile to and from treatment centers after deducting the first twenty miles one way or forty miles for each round trip;~~

~~(b) Lodging at a maximum of $25 a night; and~~

~~(c) Breakfast -$4; lunch -$4; and supper -$4~~recipient are reimbursed according to the provision of 67:16:25.

Source: 2 SDR 88, effective July 1, 1976; 6 SDR 66, effective January 10, 1980; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 7 SDR 121, effective July 2, 1981; transferred from § 67:16:23:08, 19 SDR 26, effective August 23, 1992; 21 SDR 86, effective December 29, 1994; 22 SDR 2, effective July 17, 1995; 30 SDR 193, effective June 13, 2004.

General Authority: SDCL 28-6A-12, 28-6-1.1.

Law Implemented: SDCL 28-6A-2.

67:46:10:12. Claim submission limit. All claims for services provided under this chapter ~~shall~~must be submitted to the department according to the provisions of § 67:16:35:04 ~~within 12 months after the date of service. Claims received after this time shall be denied~~.

Source: 9 SDR 28, effective September 5, 1982; transferred from § 67:16:23:10.01, 19 SDR 26, effective August 23, 1992.

General Authority: SDCL 28-6A-12.

Law Implemented: SDCL 28-6A-2.